

# Psychological Consultation Services at a Multiple Sclerosis Clinic

## A Programmatic Example

Lara M. Stepleman, PhD; Rebecca Jump, PhD; Sarah F. Shelton, PsyD; Mary D. Hughes, MD

*Despite the existence of effective treatments for mental health problems in patients with multiple sclerosis (MS), such problems often go untreated or undertreated because of a variety of patient, provider, and organizational factors. As untreated psychological difficulties can interfere with MS treatment adherence, a collaborative partnership between medical and mental health providers is crucial. In the fall of 2003, the Medical College of Georgia's Augusta MS Center implemented an MS psychological consultation service. The goal of this service is to remove barriers to the emotional well-being of individuals with MS through convenient, collaborative, and coordinated psychological services provided during routine MS medical appointments. To better understand patient use of this new program and the types of problems addressed, we conducted a retrospective review of documentation from 197 consultations held from July 2004 through June 2006. Summary data on demographics, presenting problems, and resultant treatment plans reflect a broad array of concerns for which psychological consultation was sought, including psychiatric symptoms, difficulties with adjustment to illness, and cognitive problems. Given the barriers to mental health care for MS patients and the unique skills psychologists bring to the multidisciplinary MS team, on-site psychological consultation may be an effective method of providing mental health services to the MS population. Int J MS Care. 2009;11:180–186.*

**P**ychological and emotional difficulties are very common among individuals with multiple sclerosis (MS).<sup>1</sup> Adjustment to a chronic and debilitating disease and management of a spectrum of unpredictable symptoms that interfere with quality of life contribute to the psychological burden of MS. Living with MS can be stressful, and stress itself is thought to be a factor in disease exacerbation.<sup>2</sup> Psychological symptoms related to or independent of illness, such as anxiety and depression, are believed to affect individuals with MS both directly through underlying interactions with the immune system and indirectly through behaviors.<sup>3</sup> Thus a complex array of interacting factors are involved in the function and well-being of individuals with MS.

---

From the Department of Psychiatry and Health Behavior (LMS, RJ, SFS), Department of Anesthesiology and Perioperative Medicine (RJ), and Department of Pediatrics (SFS), Medical College of Georgia, Augusta, GA, USA; and Department of Neurology, Greenville Hospital System, Greenville, SC, USA (MDH). Correspondence: Lara M. Stepleman, PhD, Department of Psychiatry and Health Behavior, Medical College of Georgia, 997 St. Sebastian Way, Augusta, GA 30912; e-mail: lsteplem@mccg.edu.

Depression is the most common psychological symptom in MS. The lifetime prevalence rate for major depressive disorder among individuals with MS is about 50%.<sup>4</sup> Depression is associated with decreased quality of life, increased MS symptoms, and reduced adherence to MS treatment regimens.<sup>5</sup> Clinically significant anxiety in MS has not been studied as extensively as depression. The point prevalence of anxiety in MS ranges from 19% to 34%.<sup>6</sup> The prevalence of bipolar disorder is also higher in MS (13%) than in the general population (1%).<sup>7</sup> Thus mood status is an important component of the overall well-being of patients with MS and an important target of comprehensive patient care.

### Mental Health Interventions in MS

Several treatment modalities exist to address the psychosocial needs of MS patients, including individual and group psychotherapy, support groups, and psychopharmacologic interventions. Individual and group psychotherapy can help patients adjust to MS and manage mood-related symptoms.<sup>1,8</sup> A Cochrane review based on

13 studies of psychological interventions in MS patients showed that cognitive-behavioral interventions are beneficial in the treatment of depression in MS, as well as helping the patient adjust to and cope with MS.<sup>9</sup> Evidence for the effectiveness of support groups and other forms of group psychotherapy is inconsistent.<sup>10</sup> However, psychotherapeutic groups that focus on psychoeducation and skill-building using a cognitive-behavioral approach have demonstrated positive outcomes.<sup>8</sup> Psychopharmacologic interventions for mood disturbance in MS patients are comparable in effectiveness to those in people without MS.<sup>11</sup> Several studies have provided empirical support for the use of antidepressant medications in MS patients.<sup>8</sup>

### Shift to Multidisciplinary MS Care

Given the number of MS patients likely to experience a clinically significant mental health problem at some point during the disease course, efficient, effective, and collaborative modes of delivering mental health services are needed. Comprehensive care centers (CCCs) have evolved in response to the continuum of needs that patients living with MS and their families may have, including medical, rehabilitative, and psychological intervention, and thus are multidisciplinary in nature.<sup>12</sup> Only a few studies, such as that of Schwartz et al.,<sup>13</sup> have quantified the benefits of using a multidisciplinary approach to MS care compared with office-based services by a primary-care physician or neurologist. Some preliminary evidence exists, however, that patients who have received services at a CCC are more likely to use providers from a variety of disciplines, experience the clinical setting as more physically accessible, and are more satisfied with their MS care than those who have not.<sup>12</sup> Moreover, patients in this same study were nearly twice as likely to have seen a psychologist if they had been treated in a CCC (15.6% vs. 8.1%).<sup>12</sup>

The provision of psychological services by a CCC, ideally at the same site as other MS services, can facilitate accessibility, provider referrals, and multidisciplinary collaboration. These factors are especially crucial in management of problems that are routinely treated across specialties, such as depression, sexual functioning, fatigue, and pain. One study found that 25% of MS patients had untreated or undiagnosed depression,<sup>14</sup> and another found that only about one-third of patients with major depression or suicidal thoughts received related

care.<sup>15</sup> The underdiagnosis and undertreatment of depression in MS are probably due to several factors, including overlap between clinical symptoms of depression and those of MS,<sup>16</sup> lack of formal screening for depression in the clinical setting,<sup>1</sup> and the need to prioritize patient concerns during MS medical visits that under managed care can be relatively brief and infrequent. Yet psychiatric symptoms can negatively affect both quality of life<sup>17</sup> and adherence to medication regimens<sup>16</sup> in MS.

### An Integrative Approach to Psychological Services

As mentioned previously, a range of mental health interventions have been discussed in the literature for individuals with MS, including support groups,<sup>18</sup> group and individual therapies,<sup>10</sup> family therapy,<sup>19</sup> and psychopharmacology.<sup>16</sup> Methods of helping patients identify their mental health needs and match them with appropriate types and levels of care are also needed. In a survey of people with MS, Eklund and MacDonald<sup>20</sup> found that although almost 60% of respondents reported having experienced a need for psychological services at some time since their MS diagnosis, nearly 30% stated that they had not received those services. Subsequently, the Goldman Consensus Statement on depression in multiple sclerosis released in 2005 recommended that clinics offer regular screening for depression and that individuals reporting symptoms be further assessed and provided with appropriate treatment recommendations.<sup>21</sup> We believe that MS-specific psychological consultation is one method of building a bridge between MS medical services and MS psychological services.

Consultation as a delivery mode for mental health services became widespread during the 1960s<sup>22</sup> and has continued to evolve, corresponding in part to growing evidence and acceptance of the mind-body connection in disease.<sup>23</sup> In addition, psychological consultation services are believed to reduce the costs of medical care, especially for patients viewed as having complex problems or not responding to standard treatment protocols.<sup>24</sup> Models of psychological consultation vary considerably, as do health-care providers in their knowledge of how to use them and for whom such referrals are appropriate.<sup>23</sup> In response to these concerns and the desire to involve patients living with chronic disease in the consultation decision-making process, Stepleman et al.<sup>25</sup> implemented

a model of patient-centered consultation (PCC) within a human immunodeficiency virus (HIV) medical clinic. The authors hold that within the medical setting, patients can be taught through screening tools and regular interaction with psychological providers how to identify their mental health needs and access psychological services in addition to—and sometimes in place of—traditional medical care. Moreover, having these providers in the clinic setting allows timely problem identification, multidisciplinary collaboration, and efficient implementation of brief interventions, possibly increasing patients' likelihood of receiving appropriate care and, when necessary, following up with longer-term care outside of the clinic. Stepleman et al. found that 2 years after implementation of the PCC model, the number of patients receiving consultation and the total number of consultations had increased by 91.5% and 83%, respectively, compared with before the implementation.

### **Purpose of the Study**

In 2003, the Medical College of Georgia's Augusta MS Center began providing psychological consultation services, adapting the PCC model for the MS environment. In response to patient and physician needs, the service has grown to include 1) depression and cognitive screening; 2) consultation meetings that include brief assessment, problem identification and refinement, and triage referral; 3) one-session intervention<sup>26</sup> on a variety of issues, including relaxation, sleep hygiene, pain management, and problem-solving; 4) crisis intervention; and 5) referral to an in-clinic brief psychotherapy program (five sessions) for patients with issues that can be addressed expediently or for symptom management during the process of referral to external mental health care providers. To improve our understanding of patient use of the new service, we reviewed documentation from a 2-year period, collecting data on the frequency of various types of patient mental health problems and resultant treatment plans. The results of this study can help elucidate the role of the psychological consultant within an MS clinic.

### **Methods**

#### **Participants**

The participants in the study were individuals who had received a psychological consultation, typically concurrently with an MS medical appointment, at the

Augusta MS Center from July 1, 2004, through June 30, 2006. The Augusta MS Center is a large regional program that served approximately 1100 patients during the 2-year study period. The center is affiliated with the Georgia Chapter and the South Carolina Regional Office of the Mid-Atlantic Chapter of the National Multiple Sclerosis Society and is a member of the Consortium of Multiple Sclerosis Centers.

One hundred ninety-seven completed consultations with 129 different patients were included in the study. The gender composition of the patients was 76% female and 24% male, and the mean age was 43.6 years (range, 18–72 years). Of the 129 participants, 58 (45%) were African American, 69 (53.5%) were white, and 2 (1.5%) were Hispanic.

#### **Procedure**

Patient use of the psychological consultation service is voluntary and can come about in several ways. The neurologist, physician's assistant, or nurse may refer the patient based on presentation during the medical appointment, or the patient can be self-referred. Psychological consultants also provide depression screening as part of routine MS appointments. Patients who report significant symptoms on the screening form are offered a consultation appointment. Consultation services generally occur on the same day and are provided by psychologists, postdoctoral fellows, or predoctoral residents receiving specialty training in MS psychology. Consultations typically last 20 to 40 minutes; if needed, a treatment plan is developed in collaboration with the patient, family, and other MS team members.

All psychological consultations performed in the Augusta MS Center are documented. The documentation consists of patient identifying information, the presenting problem(s), a description of what occurred during the consultation (including current symptom presentation and relevant biopsychosocial data), findings, and follow-up plans. For the purpose of the study, two investigators reviewed the consultation documentation from the specified time period to create an inclusive list of presenting problems and follow-up plans. This list was used to code each consultation by type of problem and treatment plan and gather frequency data for analysis. The principal investigator reviewed the coding for accuracy. As this was a retrospective study, patient consent to participate was not obtained. However, the study was approved by the

Medical College of Georgia's Human Assurance Committee before the collection of data.

## Results

### Problem Categories and Frequencies

The presenting problems were coded as 24 problem categories. The five most frequent problem categories were depression ( $n = 142$ ), anxiety ( $n = 34$ ), concerns related to a significant other ( $n = 29$ ), adjustment to MS ( $n = 25$ ), and family (not significant other) concerns ( $n = 24$ ). Further examination of the 24 categories revealed seven primary problem themes: 1) psychiatric symptoms (eg, depression, anxiety, mania), 2) adjustment issues (eg, adjustment to MS, stress), 3) family and social issues (eg, concerns related to a significant other, family concerns), 4) physical MS symptoms (eg, pain, sexual functioning), 5) MS-related cognitive problems, 6) vocational concerns, and 7) social-service needs (eg, housing, transportation). Depression was the only problem of the 24 with a high enough frequency to warrant further analysis by race and gender, given that differences in prevalence within these subgroups is often of interest. Chi-square analyses for depression by gender and for depression by race were conducted, but neither showed statistically significant differences. Table 1 provides a complete breakdown of the 7 themes and 24 problem categories.

Treatment plans resulting from consultations were coded into 18 groups. The five most frequent plans were 1) follow-up at next medical appointment ( $n = 106$ ), 2) referral to external provider for individual psychotherapy ( $n = 49$ ), 3) in-clinic psychiatric medication management ( $n = 40$ ), 4) in-clinic psychoeducation ( $n = 34$ ),

and 5) self-management strategies to practice at home ( $n = 27$ ). Table 2 provides a complete breakdown of the treatment plans by frequency.

## Discussion

The results of this study provide an overview of the frequency of various psychosocial problems and corresponding treatment plans as determined through brief psychological consultations in an MS clinic setting. These results constitute a snapshot of the most prominent psychosocial concerns of MS patients and how they can be addressed.

The psychosocial issues identified ranged from psychiatric symptoms to concerns about basic needs, such as housing and transportation. Consistent with previous studies,<sup>1</sup> depression was the most common psychological problem, with nearly three-fourths of all consultations

**Table 1. Frequency of types of patient problems**

Theme	Problem category	No. (%) of consultations (N = 197)
Psychiatric	Depression symptoms	142 (72.1)
	Anxiety symptoms	34 (17.3)
	Suicidality	14 (7.1)
	Mania	13 (6.6)
	Psychosis	10 (5.1)
	Personality disorder	6 (3.0)
	Homicidality	5 (2.5)
	Substance abuse	5 (2.5)
Adjustment issues	Adjustment to MS	25 (12.7)
	Stress	19 (9.6)
	Anger about MS	9 (4.6)
	Grief	7 (3.6)
	Body image concerns	1 (0.1)
	Life transitions (eg, moving)	1 (0.1)
Family/social concerns	Significant other concerns	29 (14.7)
	Family concerns	24 (12.2)
	Lack of social support	7 (3.6)
Physical MS symptoms	MS-related physical complaints	22 (11.2)
	Pain	10 (5.1)
	Sexual functioning	6 (3.0)
Cognitive MS symptoms		18 (9.1)
Vocational concerns		12 (6.1)
Social-service needs	Finances	5 (2.5)
	Resource needs (food, transportation)	4 (2.0)

Abbreviation: MS, multiple sclerosis.

Note: Percentages total more than 100 because each consultation was coded for up to three problems.

**Table 2. Frequency of types of treatment plans**

Treatment plan	No. (%) of consultations (N = 197)
Follow-up at next medical appointment	106 (53.8)
Referral to external provider for individual psychotherapy	49 (24.9)
In-clinic psychiatric medication management	40 (20.3)
In-clinic psychoeducation	34 (17.3)
Self-management strategies	27 (13.7)
In-clinic brief psychotherapy	25 (12.7)
No follow-up necessary at this time	17 (8.6)
Referral for psychiatric medication management	13 (6.6)
Cognitive screening/neuropsychological testing	10 (5.1)
Referral for couples/family therapy	8 (4.1)
Caregiver intervention	6 (3.0)
Referral to another medical provider (eg, PT, OT)	6 (3.0)
Referral for urgent psychiatric evaluation	4 (2.0)
Voluntary psychiatric admission	4 (2.0)
Referral for social-services follow-up	3 (1.5)
Referral to MS support group	2 (1.0)
Refused psychiatric services	2 (1.0)
Involuntary psychiatric admission	1 (0.5)

Abbreviations: MS, multiple sclerosis; OT, occupational therapist; PT, physical therapist.

Note: Percentages total more than 100 because each consultation was coded for up to three treatment plan components.

documenting this concern. Seven percent of consultations identified suicidality, highlighting the importance of addressing acute psychiatric care needs. These results have led us to modify our program to provide more depression-management services in the clinic, including modules in behavioral activation and cognitive-behavioral and problem-solving therapies for depression.

Eight of the 24 problem categories fell within the theme of psychiatric problems. Several of the low-frequency items—particularly homicidal thinking (2.5%), psychosis (5.1%), and mania (6.6%)—represent significant risk factors for the patient and possibly others as well, demanding immediate intervention. In contrast, anxiety and substance abuse problems vary in terms of the urgency of treatment. In any case, early intervention through psychological consultation and targeted treatment planning may prevent exacerbation of the problem and limit its negative effects on the MS course.

The remaining problem categories identified in this study—adjustment issues, cognitive and physical MS symptoms, family and social concerns, vocational concerns, and social-service needs—involve a diverse array of issues, many of which can be effectively addressed with short-term therapeutic interventions. For example,

brief psychotherapy can offer symptom relief through targeted skill-building and promotion of adaptive coping. Nearly 13% of the study participants were referred for brief psychotherapy. Individuals requiring more extensive treatment should be referred to an appropriate therapist. Nearly one-quarter of the study participants received this recommendation.

Several problems reported by MS patients in this sample were addressed with plans for psychoeducation (17.3%) and self-management strategies (13.8%). Psychoeducation is an effective tool to help patients understand their symptoms, normalize their experience of MS, and acquire

information and resources. It can also serve as a starting point for patients with no prior exposure to mental health treatment. Self-management strategies help patients use knowledge proactively to manage their symptoms more effectively.

Physical symptoms associated with MS exacerbations and disease progression can present challenges for patients.<sup>21</sup> In the MS consultation setting, psychologists can provide brief interventions targeting symptoms of concern. For example, MS-related pain can be debilitat-

## PracticePoints

- People with MS experience a wide array of mental health problems, and some patients come to their medical appointments with acute psychiatric care needs.
- On-site psychological consultation at MS care clinics can facilitate identification and treatment of mental health problems among MS patients.
- Depression is the most common problem for which MS patients seek psychological consultation.
- Collaboration of medical and mental health professionals is crucial in removing barriers to mental health care for MS patients.

ing and pose considerable adjustment difficulties. Evidence-based interventions such as cognitive-behavioral pain-management skills training can lead to improved coping.<sup>27</sup> Christopherson et al.<sup>28</sup> found that providing written materials to female MS patients regarding sexual problems resulted in improvements in primary sexual dysfunction. The addition of brief counseling did not lead to greater reduction in dysfunction.

Of all 129 individuals in the study sample, only 8.6% were determined to require no follow-up, and only 1% refused psychiatric care. These data indicate a high level of need for and receptiveness to psychological consultation and treatment recommendations among patients attending an MS clinic.

Although this study offers valuable information on the use of a psychological consultation service in an MS clinic, it has several limitations. First, its descriptive nature limits the interpretability and generalizability of the results. In particular, it is unknown how the individuals who received consultations differed from those who did not. In addition, whether the patient or health-care provider initiated the consultation was not consistently recorded. This is not surprising, because in good care settings, such decisions are often made collaboratively. Moreover, because the study did not follow patients after the consultations, the actual effectiveness of the service in reducing clinical symptoms is unknown. However, the primary goals of this type of consultation service are to familiarize patients with mental health care providers, improve patients' ability to evaluate their own psychological health and determine when they need assistance, make the initial assessment more convenient and collaborative, and increase access to timely care. Future research should evaluate all of these variables as well as cost-effectiveness.

Furthermore, the relatively small number of participants did not allow for additional analyses in most categories. In addition, the sample is geographically limited to a single regional MS clinic. Another concern is the potential for inconsistency in the clinical documentation and in coders' ratings of that documentation. Although all consultants are trained in a specific consultation format and a supervisor reviewed the documentation, personal documentation style affects the content. Similarly, despite the use of more than one coder, the subjective nature of the coding procedure may reflect personal biases that could skew the results.

The purpose of this study was to collect and examine a preliminary set of data on the development of a unique psychological consultation service for MS patients. Future studies should include a comparison group consisting of patients who refused or did not receive consultations. In addition, a postconsultation follow-up component to determine the number of patients who followed up with treatment planning recommendations would be useful. Pre- and postconsultation comparisons would allow for evaluation of both general (across treatment recommendations) and specific (within treatment recommendations) outcomes.

As this study demonstrates, a wide range of psychosocial issues can be identified and addressed using this model of care. Additional research will focus on how this type of service can best be practiced across a variety of MS settings. □

---

**Acknowledgments:** The authors gratefully acknowledge the Multiple Sclerosis Foundation, the Dana and Christopher Reeve Foundation, and the Teva Neuroscience Foundation, which provided funding during the 2004–2006 time period that provided patient access to psychological consultation services at the Medical College of Georgia's Augusta MS Center regardless of ability to pay.

---

**Financial Disclosures:** The authors have no conflicts of interest to disclose.

#### References

1. Minden SL. Mood disorders in multiple sclerosis: diagnosis and treatment. *J Neurovirol.* 2000;6(suppl 2):S160–167.
2. Mohr DC. Stress and multiple sclerosis. *J Neurol.* 2007;254(suppl 2):1165–68.
3. Mohr DC, Cox D. Multiple sclerosis: empirical literature for the clinical health psychologist. *J Clin Psychol.* 2001;57:479–499.
4. Sadovnick AD, Remick RA, Allen J, et al. Depression and multiple sclerosis. *Neurology.* 1996;46:628–632.
5. Mohr DC, Hart SL, Julian L, Tasch ES. Screening for depression among patients with multiple sclerosis: two questions may be enough. *Mult Scler.* 2007;13:215–219.
6. Stenager E, Knudsen L, Jensen K. Multiple sclerosis: correlation of anxiety, physical impairment and cognitive dysfunction. *Ital J Neurol Sci.* 1994;15:97–101.
7. Joffe RT, Lippert GP, Gray TA, Sawa G, Horvath Z. Mood disorder and multiple sclerosis. *Arch Neurol.* 1987;44:376–378.
8. Wallin MT, Wilken JA, Turner AP, Williams RM, Kane R. Depression and multiple sclerosis: review of a lethal combination. *J Rehabil Res Dev.* 2006;43:45–62.
9. Thomas PW, Thomas S, Hillier C, Galvin K, Baker R. Psychological interventions for multiple sclerosis. *Cochrane Database Syst Rev.* 2006;1:CD004431.
10. Mohr DC, Boudewyn AC, Goodkin DE, Bostrom A, Epstein L. Comparative outcomes for individual cognitive-behavior therapy, supportive-expressive group psychotherapy, and Sertraline for the treatment of depression in multiple sclerosis. *J Consult Clin Psychol.* 2001;69:942–949.
11. Silver JM, Hales RE, Yudofsky SC. Psychopharmacology of depression in neurologic disorders. *J Clin Psychiatry.* 1990;51 suppl:33–39.

12. Sutton JP, Schur C, Feldman J, Tyry R. Comprehensive care centers and treatment of people with multiple sclerosis. *Int J MS Care*. 2007;9:104–110.
13. Schwartz CE, Brotman S, LaRocca N, Lee H. Patient perception of quality of care provided by specialists and generalists. *Mult Scler*. 1998;4:426–432.
14. McGuigan C, Hutchinson M. Unrecognized symptoms of depression in a community-based population with multiple sclerosis. *J Neurol*. 2006;253:219–223.
15. Feinstein A. An examination of suicidal intent in patients with multiple sclerosis. *Neurology*. 2002;59:674–678.
16. Mohr DC, Goodkin DE, Likosky W, Gatto N, Baumann KA, Rudick RA. Treatment of depression improves adherence to interferon beta-1b therapy for multiple sclerosis. *Arch Neurol*. 1997;54:531–533.
17. Janardhan V, Bakshi R. Quality of life in patients with multiple sclerosis: the impact of fatigue and depression. *J Neurol Sci*. 2002;205:51–58.
18. Uccelli MM, Mohr LM, Battaglia MA, Zagami P, Mohr DC. Peer support groups in multiple sclerosis: current effectiveness and future directions. *Mult Scler*. 2004;10:80–84.
19. Long MP, Glueckauf RL, Rasmussen JL. Developing family counseling interventions for adults with episodic neurological disabilities: presenting problems, persons involved, and problem severity. *Rehabil Psychol*. 1998;43:101–117.
20. Eklund V, MacDonald ML. Descriptions of persons with multiple sclerosis with an emphasis on what is needed from psychologists. *Prof Psychol Res Pract*. 1991;22:277–284.
21. Goldman Consensus Group. The Goldman Consensus Statement on depression in multiple sclerosis. *Mult Scler*. 2005;11:328–337.
22. Caplan G, Caplan RB, Erchul WP. A contemporary view on mental health consultation: comments on “Types of mental health consultation” by Gerald Caplan (1963). *J Educ Psychol Consult*. 1995;6:23–30.
23. Hutton KM, Williams M. Assessment of psychological issues and needs in the specialties of a large teaching hospital. *Psychol Health Med*. 2001;6:313–319.
24. Croake JW. Combining consultation and psychotherapy or one-session psychotherapy. *J Indiv Psychol*. 1999;55:26–30.
25. Stepleman LM, Hann G, Santos M, House AS. Reaching underserved HIV-positive individuals by using patient-centered psychological consultation. *Prof Psychol Res Pract*. 2006;37:75–82.
26. Dingfelder SF. Make the most of one session. *Monitor on Psychol*. 2008;39:40–41.
27. Turk DC, Swanson KS, Tunks ER. Psychological approaches in the treatment of chronic pain patients—when pills, scalpels, and needles are not enough. *Can J Psychiatry*. 2008;35:213–223.
28. Christopherson JM, Moore K, Foley FW, Warren KG. A comparison of written materials vs. materials and counselling for women with sexual dysfunction and multiple sclerosis. *J Clin Nurs*. 2006;15:742–750.